

Contamination and Symptoms of Buruli Ulcer: A Neglected Tropical Disease

Edwin Simpson*

Department of Disease Control, London School of Hygiene and Tropical Medicine, London, UK

DESCRIPTION

The second most prevalent mycobacterial disease in West Africa, buruli ulcer is a necrotizing skin condition that can have serious consequences for affected person. Mycobacterium ulcerans, whose main virulence factor is mycolactone, is the pathogen that causes the illness. Although an early infection can be treated with antibiotics, developing a successful prevention strategy is difficult since the reservoir(s) and mode(s) of transmission are unclear. The burden of disease and its expenditures are further complicated by the incidence of diseases in remote areas with little access to medical facilities.

Mycobacterium ulcerans is an ecological bacterium that is known worldwide as buruli ulcer, leading an infectious disease. It is also known as the daintree ulcer in Australia. It is a skin condition that is a neglected tropical disease. Critical skin and soft tissue lesions are caused, which can lead to serious damage, death, disability, and deformity. The majority of bacteria are found in damp, marshy areas.

The majority of bacteria are found in damp, marshy areas. The possibility for cooperation between these two disease processes arises from the fact that the disease-causing organism is a member of the same bacterial family as leprosy and tuberculosis. However, because the bacteria are unknown, it is unclear how they were transmitted from an ambient germ to humans. However, it has been discovered that early diagnosis and treatment are essential for reducing morbidity, bringing down expenses, and averting permanent disability.

Buruli ulcer starts as a painless, frequently irritating bump or papule on the skin, which the patient frequently ignores. The severity of the ailment causes the majority of patients to wait a long time before seeking medical attention. If this nodule is not treated, it causes severe skin ulceration and other severe problems such contracture deformities, limb amputation, and organ failure.

Bone infections could develop as a direct result of the surrounding skin lesion spreading. The bacterium's toxin destroys tissues, and it has just been discovered what kind of chemicals are thought to be the poisons. Surgery has historically been the preferred course of treatment, however the majority of endemic regions in the developing world lack access to adequate surgical facilities.

It has been known for more than 50 years that buruli ulcer is contracted through exposure to the environment, frequently through contact with still or slowly flowing bodies of water. Buruli ulcer cases have been reported everywhere in the world, including in Africa, America, Asia, and the Western Pacific.

CONCLUSION

The disease may be transmitted to humans by specific insects found in water, which is one way that individuals may come into contact with it. Even though there is no proof that human and animal infections are related, some animals can contract the illness. Buruli ulcer symptoms include skin edoema, skin damage, and soft tissue damage. In general, patients with painless ulcers who are ill should visit a doctor and receive antibiotics. If these antibiotics are not administered promptly after getting unwell, the condition may frequently result in deformity, physical disability (such as restricted joint movement), bone infection, and secondary bacterial infection with skin ulcer sores.

Received: 30-Sep-2022, Manuscript No. JTD-22-18739; Editor assigned: 04-Oct-2022, PreQC No. JTD-22-18739(PQ); Reviewed: 18-Oct-2022, QC No. JTD-22-18739; Revised: 27-Oct-2022, Manuscript No. JTD-22-18739 (R); Published: 03-Nov-2022, DOI:10.35248/2329-891X.22.10.354.

Citation: Simpson E (2022) Contamination and Symptoms of Buruli Ulcer: A Neglected Tropical Disease. J Trop Dis. 10:354.

Copyright: © 2022 Simpson E. This is an open access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Correspondence to: Edwin Simpson, Department of Disease Control, London School of Hygiene and Tropical Medicine, London, UK, E-mail: simpson_edwin@gmail.com